Health Partnership
CLINIC

Patient Registration

Updated Annually

PATIENT INFORMATION **DATE:**___________________

Full Legal Name: ____
First Middle Initial Last

Address: __________________________________ Apt No: ______________

City: ____________________ State: ______________ Zip: ____________________

Date of Birth: __________________ Social Security Number: _______________________

Sex: Male _____________ Female __________ Marital Status: _______________________

Cell Phone: ______________ Home Phone: ______________ Work Phone: ____________________

E-mail Address: ____

We are required to request the following information for federal funding.

RACE
- □ American Indian/Alaskan
- □ Asian
- □ Black/African American
- □ Native Hawaiian
- □ Another Pacific Islander
- □ White
- □ Other/More than one race

ETHNICITY
- □ Hispanic/Latino
- □ Not Hispanic/Latino
- □ Refuse to report

Housing Status
- □ Not Homeless
- □ Shelter
- □ Street
- □ Doubling Up
- □ Transitional
- □ Other

GENDER IDENTITY
- □ Male
- □ Female
- □ Male to Female
- □ Female to Male
- □ Gender Neutral
- □ Declined to Specify
- □ Other

Sexual Orientation
- □ Heterosexual
- □ Gay, Lesbian or Homosexual
- □ Bisexual
- □ Something Else
- □ Don't Know
- □ Declined to Specify

Sex at Birth
- □ Male
- □ Female
- □ Unknown
- □ Declined to Specify

Have you or has anyone in your household worked in agriculture, such as planting, cultivating, or harvesting agriculture products (fruits, vegetables, grains, or dairy) in the last two years? □Yes □No

Are you a veteran? □Yes □No

RESPONSIBLE FINANCIAL PARTY (if patient is under 18 years of age)

Full Legal Name: ____
Last Middle Initial First

Date of Birth: __________________ Social Security Number: _______________________

Address: ____

City: ____________________ State: ______________ Zip: ____________________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ____________________

Relationship to Patient: ____________________ E-mail Address: ____________________

PROTECTED HEALTH INFORMATION

The undersigned acknowledges receipt of the Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. I hereby authorize the verbal release of my Protected Health Information for discussion of my care, treatment, and/or payment to the person(s) specified below. (45CFR 164.502(F) & 164.502 (G))

Please list any other parties who can have access to your health information:

1. ____
Name Relationship Phone

2. ____
Name Relationship Phone

3. ____
Name Relationship Phone

HEALTH INFORMATION EXCHANGE

Health Partnership Clinic participates in electronic health information technology or HIT. This technology allows a provider or a health plan to make a single request through a health information organization (HIO) to obtain electronic records for a specific patient from other HIT participants for purposes of treatment, payment, or health care operations. HIOs are required to use appropriate safeguards to prevent unauthorized uses and disclosures. You have two options with respect to HIT. First, you may permit authorized individuals to access your electronic health information through an HIO. If you choose this option, you do not have to do anything.
Second, you may restrict access to all of your information through an HIO (except as required by law). If you wish to restrict access, you must submit the required information either online at http://www.KanHIT.org, or by completing and mailing a form. This form is available at http://www.KanHIT.org. You cannot restrict access to certain information only; your choice is to permit or restrict access to all of your information. If you have questions regarding HIT or HIOs, please visit http://www.KanHIT.org for additional information.

CONFIDENTIALITY: I am aware that information about my treatment is considered confidential and will be used in a manner consistent with proper professional conduct and will only be released to outside sources under applicable state and federal law statutes and regulations or when ordered by a court of competent jurisdiction.

______________________________ ______________________
Patient/Legal guardian Signature Date

CONSENT FOR TREATMENT

Health Partnership Clinic (HPC) is dedicated to providing primary care, dental care and mental health services. Because physical and emotional problems often go together, we believe the best care is given when health care providers work together. HPC patients may be referred to providers from other health care specialties within the HPC treatment team. Members of the treatment team will share clinical information with each other as is clinically necessary.

I understand that my health care provider(s) may offer telehealth consultations. I understand that there are potential risks to this technology including interruptions and technical difficulties. I understand that video conferencing technology will be used to affect a consultation and will not be the same as a direct patient/provider visit due to the fact that I will not be in the same room as my health care provider.

I understand HPC reserves the right to limit or dismiss any individual from accessing HPC services. Such limitations may result for reasons including, but not limited to, failure to provide 24 hours' notice of appointment cancellation, disruptive or abusive behavior, refusal to follow recommended healthcare treatment, and fraud.

I understand that HPC is approved to train students. I also understand students may observe or participate in patient care. I permit such involvement, unless I notify HPC to the contrary in writing, with the understanding that the student's work will be under the supervision of a qualified instructor or staff of HPC.

While a patient of HPC, I hereby consent to care and treatment, including but not limited to diagnostics, therapeutic testing and treatment as may be deemed necessary or advisable by my care provider, his/her associates, or designees which may be advisable and necessary based on his/her knowledge and my health condition. I understand that no guarantees have been made to me about the outcome of this care.

FINANCIAL INFORMATION

Financial Agreement: I hereby assign to Health Partnership Clinic, any and all benefits payable from any policy of insurance covering the patient or person responsible for the patient's care (including but not limited to Medicare, Medicaid, commercial insurance policies, etc.) to be paid directly to HPC to be applied to the charges for services rendered. **I understand I am responsible for fee at time of service, co-insurance payments, deductibles and/or any remaining balance**. In the event pre-certification for such treatment is required by any health plan or insurance policy, the patient or agent is responsible for obtaining such pre-certification.
Services provided in addition to the original scheduled appointment, may result in higher fee for service than quoted.

Medicare/Medicaid: The patient or agent affirms that the information provided in applying for payment under Social Security Act Title XVIII (Medicare), State Medicaid laws or any other federal or state Social Security Act Title XVIII program is correct and authorizes HPC, or its employees or agents to provide medical or other information necessary for processing a claim to any government agency or their intermediaries or insurance carriers. Request is hereby made for payment of authorized benefits on patient's behalf.

Medicare/Medicaid Non-Covered Service: I understand that if Medicare and Medicaid do not pay for some services that I am fully responsible for payment of this service.

It may be necessary to restrict access to patients who, after all efforts have been exhausted, fail to fulfill their financial responsibilities to HPC. Patient files could be flagged to this effect and appointments not accepted in cases of consistent non-payment & you will be considered for dismissal from the clinic.

____ ____________________

Patient/Legal Guardian Signature Date

Copy available upon request, information also available on the website https://hpcks.org and patient portal